

PROVIDING AN INDIAN MENTAL HEALTH DEMONSTRATION GRANT PROGRAM

OCTOBER 11, 1990.—Ordered to be printed

Mr. UDALL, from the Committee on Interior and Insular Affairs,
submitted the following

REPORT

[To accompany S. 1270 which on November 17, 1990, was referred jointly to the
Committee on Energy and Commerce and the Committee on Interior and Insular
Affairs]

[Including cost estimate of the Congressional Budget Office]

The Committee on Interior and Insular Affairs, to whom was referred the bill (S. 1270) to provide an Indian mental health demonstration grant program, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Page 1, line 3, strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Indian Health Care Amendments of 1990".

SEC. 2. REFERENCES.

Except as may otherwise be specifically provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Indian Health Care Improvement Act (25 U.S.C. 1601, et seq.).

TITLE I—MENTAL HEALTH SERVICES

SEC. 101. MENTAL HEALTH PREVENTION AND TREATMENT SERVICES.

Title II of the Act is amended by adding at the end thereof the following new section:

"MENTAL HEALTH PREVENTION AND TREATMENT SERVICES

"SEC. 208. (a) PURPOSE.—The purpose of this section is to—

"(1) authorize and direct the Service to develop a comprehensive mental health prevention and treatment program;

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"(2) provide direction and guidance relating to mental illness and dysfunctional/self-destructive behavior, including child abuse and family violence, to those Federal, tribal, and State and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services;

"(3) assist Indian tribes at the local level in identifying existing programs and resources, including those made available by this section;

"(4) provide authority and opportunities for Indian tribes to develop, implement, and coordinate community-based mental health programs which include identification, prevention, education, referral, and treatment services, including multi-disciplinary resource teams;

"(5) ensure that Indian people, as citizens of the United States and of the states wherein they reside, have access to mental health care services to which all citizens are entitled, and

"(6) modify or supplement existing programs and authorities in the areas identified in paragraph (2).

"(b) NATIONAL PLAN FOR INDIAN MENTAL HEALTH SERVICES.—(1) The Secretary, acting through the Service, shall develop and publish in the Federal Register a final National Plan for Indian Mental Health Services not later than 120 days after the date of enactment of this section. The plan shall include—

"(A) an assessment of the scope of the problem of mental illness and dysfunctional/self-destructive behavior, including child abuse and family violence, among Indian people, including—

"(i) the number of Indians served by the Service who are directly or indirectly affected by such illness or behavior, and

"(ii) an estimate of the financial and human cost attributable to such illness or behavior;

"(B) an assessment of the existing and needed resources necessary to adequately support a program for the prevention and treatment of such illness and behavior among Indian people; and

"(C) an estimate of the funding necessary to adequately support such program.

"(2) The Secretary shall submit a copy of the National Plan to the Congress.

"(c) MEMORANDUM OF AGREEMENT.—Not later than 180 days after the date of enactment of this section, the Secretary and the Secretary of the Interior shall develop and enter into a Memorandum of Agreement which shall, among other things,—

"(1) determine and define the scope and nature of mental illness and dysfunctional/self-destructive behavior among Indian people;

"(2) make a preliminary assessment of the existing Federal, tribal, state and local, and private resources and programs available for inclusion in a coordinated, comprehensive mental health program for Indian tribes;

"(3) make an initial determination of the unmet need for resources and programs necessary to identify, prevent, and treat mental illness and dysfunctional/self-destructive behavior, including child abuse and family violence, among Indians;

"(4) in carrying out the intent of subsection (a)(5), determine the right of Indians to participate in, and receive the benefit of, mental health services and programs made available to citizens generally and to outline actions necessary to protect the exercise of such right;

"(5) delineate the responsibilities of the Bureau of Indian Affairs and the Service to provide mental health identification, prevention, education, referral, and treatment services, including multi-disciplinary resource teams, to Indians at the central, area, and agency and service unit levels;

"(6) provide a strategy for the coordination of the mental health programs and efforts of such agencies existing on the date of enactment of this section with other available resources and programs identified pursuant to paragraph (2) and with programs and efforts established by this section;

"(7) in the development of the strategy required by paragraph (6), outline plans to ensure that—

"(A) the alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and the various tribes be fully coordinated with the mental health initiatives established in this Act, particularly with respect to the referral and treatment of dually-diagnosed persons,

"(B) Indian tribes are afforded an equitable opportunity for funding under the Alcohol and Drug Abuse and Mental Health Service Block Grant program (42 U.S.C. 300x et seq.), and

"(C) ensure that multi-disciplinary resource teams addressing child abuse and family violence are coordinated with Service and non-Service programs;

"(8) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and service unit levels, to cooperate fully with tribal requests made pursuant to subsection (d);

"(9) provide for an annual review of such agreement by the two Secretaries; and

"(10) provide that funds under subsection (i) shall be available to accomplish the requirements of this section.

"(d) COMMUNITY MENTAL HEALTH PLAN.—(1) The governing body of any Indian tribe may, at its discretion, adopt a resolution for the establishment of a Community Mental Health Plan to identify and coordinate available resources and programs, including resources and programs made available by this section, to identify, prevent or treat mental illness or dysfunctional/self-destructive behavior, including child abuse and family violence, among its members. The resolution adopted by the tribe shall form the basis for the implementation of this section and the Memorandum of Agreement under subsection (c) within the reservation of such tribes.

"(2) In furtherance of a Plan to be adopted pursuant to paragraph (1) and at the request of a tribe, the appropriate agency, service unit, or other officials of the Bureau of Indian Affairs and the Service shall cooperate with, and provide technical assistance to, the tribe in the development of such plan. Upon the adoption of a plan by the tribe, such officials, as directed by the Memorandum of Agreement developed pursuant to subsection (c), shall enter into an agreement with the tribe for the implementation of such plan.

"(3) Two or more Indian tribes may form a coalition for the adopting of resolutions and the development of a joint Community Health Plan for their members as provided in this subsection.

"(4) The Secretary, acting through the Service, may make grants to Indian tribes adopting a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a Community Mental Health Plan and to provide administrative support in the implementation of such plan. There is hereby authorized to be appropriated \$1,000,000 for each of the fiscal years 1992, 1993, and 1994 to carry out this subsection.

"(e) MENTAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.—(1) The Secretary and the Secretary of the Interior, in consultation with representatives of Indian tribes, shall conduct an study, and compile a list, of—

"(A) the types of staff positions within the Bureau of Indian Affairs, including existing positions in the fields of—

"(i) elementary and secondary education,

"(ii) social services and family and child welfare,

"(iii) law enforcement and judicial services, and

"(iv) alcohol and substance abuse;

"(B) types of health care positions within the Service; and

"(C) staff positions similar to those identified in subparagraphs (A) and (B) established and maintained by Indian tribes, including positions established in contracts entered into pursuant to the Indian Self-Determination Act, the qualifications for which include, or should include, training in the identification, prevention or treatment of mental illness or dysfunctional/self-destructive behavior among Indian people.

"(2)(A) The respective Secretaries shall provide that training criteria have been, or will be, established for each position identified in paragraph (1) (A) and (B), depending upon the functions and responsibilities assigned to such positions, and that the appropriate training has been, or will be, provided to any incumbent of such positions.

"(B) Depending upon the nature of the position, the respective Secretaries shall provide relevant training to, or provide funds to an Indian tribe to support the training of, the incumbents of positions identified in paragraph (1)(C). Where such positions are funded under an Indian Self-Determination Act contract, the appropriate Secretary shall ensure that such training costs are included in the contract, if necessary.

"(C) If a Plan adopted pursuant to subsection (d) identifies personnel or staff positions, other than those identified pursuant to paragraph (1), which provide services or benefits to Indians on an Indian reservation for which training authorized by this subsection or community education programs are deemed necessary or desirable, such training or community education may be provided from funds authorized pursuant to this subsection.

"(3) Position-specific training standards in the identification, prevention, and treatment of mental illness and dysfunctional/self-destructive behavior, including child abuse and family violence, among Indians shall be consistent with any national standards for the training of the incumbents of similar positions. However, such training shall also adopt and apply identification, prevention and treatment methods which are culturally relevant to Indian people and Indian communities. Specifically, the respective Secretaries shall ensure that established and recognized traditional Indian healing and treatment practices are considered and, where appropriate, included in any training programs developed pursuant to this subsection.

"(4) The Service shall develop and implement or, upon the request of the Indian tribe or tribes served by a service unit, assist such tribes to develop and implement within each service unit a program of community education on mental illness and dysfunctional/self-destructive behavior for persons within the tribal communities as determined in a plan adopted pursuant to subsection (d). In carrying out this paragraph, the Service shall provide technical assistance to tribes to obtain or develop community education and training materials on the identification, prevention, referral and treatment of mental illness and dysfunctional/self-destructive behavior.

"(5) There is hereby authorized to be appropriated \$5,000,000 for each of the fiscal years 1992, 1993, and 1994 to carry out this subsection, \$1,200,000 of which shall be allocated for community education under paragraph (4).

"(f) STAFFING.—(1) Within 90 days after the date of enactment of this section, the Secretary shall develop a plan under which the Service will increase the health care staff supported by mental health categorical funds by at least 500 positions within five years after the date of enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. Such additional staff shall be primarily assigned to the service unit level for services which shall include outpatient, emergency, aftercare and follow-up, and prevention and education services.

"(2) Implementation of the plan adopted pursuant to paragraph (1) shall be as authorized under the Snyder Act of November 2, 1921 (42 Stat. 208; 25 U.S.C. 13).

"(g) STAFF RECRUITMENT AND RETENTION.—(1) To support the recruitment of increased personnel authorized by subsection (f) and the retention of all Service personnel devoted to mental health service (particularly services for child and adolescent mental health specialists), the Secretary shall provide that a high priority is given to such needs in implementing the scholarship and manpower provisions of title I of this Act and in any other recruitment and retention efforts of the Department of Health and Human Services.

"(2) To assist in the recruitment and retention of mental health professionals as provided in paragraph (1), the Secretary shall develop a plan for the payment of bonuses for service in hardship posts, a loan repayment initiative to recruit such personnel, and a system of postgraduate rotations as a retention initiative.

"(3) For the purpose of carrying out special efforts for the recruitment and retention of mental health professionals as provided in this subsection, there is authorized to be appropriated \$1,200,000 for each of the fiscal years 1992, 1993, and 1994.

"(h) MENTAL HEALTH TECHNICIAN PROGRAM.—(1) Under the authority of the Snyder Act of November 2, 1921 (25 U.S.C. 13), the Secretary shall establish and maintain a Mental Health Technician Program within the Service which—

"(A) provides for the training of Indians as mental health technicians, and

"(B) employs such technicians in a community-based mental health care program offering identification, prevention, education, referral, and treatment services.

"(2) The Secretary shall provide that persons selected for participation in the Mental Health Technician program are provided with high standard paraprofessional training in mental health are necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

"(3) The Secretary shall develop and maintain a system which provides close supervision of mental health technicians and which permits the work of such technicians to be reviewed and evaluated.

"(4) The Secretary shall ensure that the program established pursuant to this subsection shall involve the utilization and promotion of traditional health care practices of the Indian tribes to be served.

"(5) There is hereby authorized to be appropriated \$1,000,000 to provide the training required pursuant to this subsection.

"(i) MENTAL HEALTH RESEARCH.—(1) The Secretary, acting through the Service and with appropriate collaboration from the National Institute of Mental Health,

shall enter into a contract with, or make a grant to, appropriate institutions to conduct research on the incidence and prevalence of mental disorders among Indian populations on Indian reservations and in urban areas as provided in this subsection. Research priorities should include the inter-relationship and inter-dependence of such mental disorders with alcoholism, suicide, homicides, accidents, and the incidence of family violence and should focus on prevention techniques, with an emphasis on children.

"(2) There is hereby authorized to be appropriated to carry out this subsection \$2,000,000.

"(j) **FACILITIES ASSESSMENT.**—Within one year after the date of enactment of this section, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indian people and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary should consider the possible conversion of existing, under-utilized Service hospital beds into psychiatric units to meet such need. There is authorized to be appropriated \$500,000 to make the assessment required by this subsection.

"(k) **ANNUAL REPORT.**—The Secretary shall require the Service to develop methods for analyzing and evaluating the over-all status of mental health programs for Indian people and shall submit to the Congress an annual report on the mental health status of Indian people and the progress being made to address mental health problems of Indian communities nationwide.

"(l) **MENTAL HEALTH DEMONSTRATION GRANT PROGRAM.**—(1) The Secretary, acting through the Service, is authorized to make at least five grants to Indian tribes or inter-tribal consortia to pay 75 percent of the cost of planning, developing, and implementing programs proposed in applications by such tribes or consortia that will deliver mental health services to Indians through innovative and community-based means. The 25 percent local share of the tribe or tribal consortium may be provided in cash or through the provision of property and services.

"(2) In approving applications for grants pursuant to this subsection, the Secretary shall ensure that the grants awarded are not duplicative in the nature and scope of the innovative programs or delivery systems to be demonstrated or the population to be served by the demonstration programs. In addition to other relevant factors, the Secretary, in selecting the applications for approval, shall take into consideration—

"(A) the geographic and cultural diversity among the Indian tribes,

"(B) the potential impact upon urban Indian mental health problems, and

"(C) the variation in mental health problems afflicting different tribes.

"(3) Applications submitted pursuant to paragraph (1) shall be in such form as the Secretary may prescribe and shall specify—

"(A) the nature of the innovative and community-based means for the delivery of mental health services to be demonstrated in the proposed program;

"(B) the data and information upon which the program is based;

"(C) the extent to which the program plans to use or incorporate existing service delivery activities;

"(D) the specific treatment concepts to be used under the program;

"(E) the extent of the planned use under the program of traditional Indian healing and treatment practices; and

"(F) a schedule for the completion of the program within three years.

"(4) Grants made pursuant to this subsection shall be for a period of three years and no grant shall exceed \$1,000,000 for each of the three fiscal years involved.

"(5) The Secretary shall adopt such regulations as are necessary—

"(A) for the consideration and approval of applications submitted pursuant to paragraph (1), including the establishment of peer group review panels;

"(B) to ensure that the grant funds are expended for the purposes for which the grant was made; and

"(C) for the evaluation of the effectiveness of the program in meeting the mental health needs of the population to be served.

"(6) Not later than 180 days after the close of the term of the last grant awarded pursuant to this subsection, the Secretary shall submit to the Congress a final report evaluating the effectiveness of the innovative and community-based models tested in the demonstration programs funded and any findings or recommendations relating to the re-organization of the Service's programs for mental health service delivery for Indians.

"(7) There is hereby authorized to be appropriated \$3,000,000 for each of the fiscal years 1992, 1993, and 1994 to carry out the purposes of this subsection."

TITLE II—HEALTH CARE DELIVERY

SEC. 201. HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.

(a) DEFINITION.—Section 4 of the Act (25 U.S.C. 1603) is amended by adding at the end thereof the following new subsection:

“(m) ‘Health Care Delivery Demonstration Project’ means a project approved by the Secretary pursuant to section 307 for Indian tribes to support the design and implementation of innovative approaches for the delivery of cost effective health care to Indians which does not merely replicate existing models of Service and tribal health care programs and which may include, among other things,—

“(1) innovative use of existing Service health care facilities, resources, and funds;

“(2) the infusion of non-Service funds into the construction of Service or tribal health care facilities;

“(3) the coordination of Service and non-Service Federal programs, services, and funds; and

“(4) cooperative agreements involving Service, tribal, State and local governmental, and private health care facilities and resources for the provision of health care services to Indians and non-Indians in rural communities.”.

(b) ESTABLISHMENT OF PROGRAM.—Title III of the Act is amended by adding at the end thereof the following new section 307:

“INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT

“SEC. 307. (a) FINDINGS.—The Congress finds that—

“(1) there is a unique relationship between the Federal Government and Indian tribes, and this section is not intended to alter that relationship;

“(2) every Indian tribe, regardless of its size, should have the ability to provide the highest possible level of health services to its people;

“(3) the existing Services facilities construction priority system and resource allocation methodologies shall not be affected by this section;

“(4) the existing facilities construction priority system does not serve all tribes and there are some small Indian tribes with a low patient workload at existing facilities which may require reconstituted Service support; and

“(5) there exists an Indian health facilities construction backlog which will require at least \$596,000,000 to remedy, and an essential repair backlog which will require at least \$94,000,000 to remedy.

“(b) PURPOSE.—The purpose of this section is to authorize demonstration projects which are intended to identify the most effective and efficient means of providing access to health care and essential health services for Indians. This section will—

“(1) enable Indian tribes to devise alternative health care delivery systems utilizing existing and new Service resources combined with other resources;

“(2) enable Indian tribes to develop and implement financing mechanisms for health care services provided through an alternative delivery system; and

“(3) enable Indian tribes to fully utilize all available resources for the benefit of community members, whether eligible or ineligible for services provided by the Service, through an existing or alternative health care system.

“(c) HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.—(1) The Secretary, acting through the Service, is authorized to enter into contracts with, or make grants to, Indian tribes or tribal organizations for the purposes of carrying out a Health Care Delivery Demonstration Project to test innovative health care delivery systems which can, effectively and efficiently, carry out the responsibility of the United States to provide health facilities and services to Indians.

“(2) The Secretary, in approving projects pursuant to this section, may authorize funding for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

“(A) waive any leasing prohibition;

“(B) permit carryover of funds appropriated for the provision of health care services;

“(C) permit the use of non-Service Federal funds and non-Federal funds;

“(D) permit the use of funds or property donated from any source for project purposes; and

“(E) provide for the reversion of donated real or personal property to the donor.

“(3) In approving applications for demonstration projects pursuant to this section, the Secretary shall—

“(A) to the maximum extent feasible, provide for a fair geographic distribution of such projects among the Indian tribes; and

"(B) select for consideration and approval projects (including projects approved pursuant to paragraph (4)) which include proposals involving the construction or renovation of facilities—

"(i) with funds from sources other than the Service,

"(ii) with funds from the Service representing not less than 25 percent and not more than 75 percent of the total cost, and

"(iii) with 100 percent funding from the Service, and shall give consideration to the funding of at least one proposal involving each of these funding options.

"(4) Notwithstanding paragraph (3) and subject to the availability of funds, the Secretary shall establish, upon the submission of an application meeting the requirements of subsection (d) by the appropriate Indian tribe or tribal organization, a demonstration project located in each of the following Service units:

"(A) Cass Lake, Minnesota,

"(B) Clinton, Oklahoma,

"(C) Harlem, Montana,

"(D) Mescalero, New Mexico,

"(E) Owyhee, Nevada,

"(F) Parker, Arizona,

"(G) Schurz, Nevada,

"(H) Winnebago, Nebraska, and

"(I) Ft. Yuma, California.

"(5) No Indian tribe or tribal organization shall be denied eligibility to participate in a project authorized by this section based solely on the financial resources of the tribe or organization.

"(d) PROJECT APPLICATIONS.—(1) Any Indian tribe or tribal organization requesting a demonstration project shall submit an application to the Secretary in conformity with the provisions of this subsection.

"(2) The application shall be in such form as the Secretary shall prescribe and shall include—

"(A) an assessment of existing health care resources and needs of the community to be served, including—

"(i) a description of the community and area to be served by the project;

"(ii) a complete description and analysis of existing health care facilities and health services currently available to the population served; and

"(iii) a description of funds available for existing health care services and facilities; and

"(B) a full description of the proposal for an new or innovative health care delivery system to be operated and tested under such demonstration project, including—

"(i) the need for project;

"(ii) the data and information on which the proposal is based;

"(iii) a description of the health care services to be provided in connection with the project;

"(iv) a description of any health care facilities to be constructed or renovated under the project, including a schedule for completion of such facilities;

"(v) an assessment of the staffing needs for the provision of services and operation of facilities in connection with such project;

"(vi) an assessment of the costs of the project and the identification and verification of the funding sources for such project, including a full account of non-Service and non-Federal funds;

"(vii) an explanation of the factors which make the demonstration project unique; and

"(viii) statements from the tribal governments and organizations, local governments and institutions, and any existing health service delivery systems in the area which would be participating in, or affected by, the demonstration project.

"(e) REVIEW AND APPROVAL OF APPLICATIONS.—(1) Within 180 days after the date of enactment of this section, the Secretary, after consultation with Indian tribes and tribal organizations, shall develop and publish in the Federal Register criteria for the review and approval of applications submitted for demonstration projects under this section. A copy of the proposed criteria shall be submitted to the Senate Select Committee on Indian Affairs and the House Committee on Interior and Insular Affairs and the House Committee on Energy and Commerce.

"(2)(A) The criteria developed pursuant to paragraph (1) shall provide for the establishment by the Secretary of peer review panels, as necessary, to review, evalu-

ate and rank applications submitted pursuant to this section and to make recommendations thereon to the Secretary.

"(B) A panel established pursuant to this paragraph shall include at least one member who is a tribal representative, a Service employee, an expert in rural health, and an expert in health facility construction and program implementation.

"(C) In reviewing, evaluating and ranking applications pursuant to this paragraph, review panels shall consider, among other things—

"(i) whether the demonstration project will provide innovative health services to Indian people;

"(ii) the benefit or benefits to the Indian community in the operation of the demonstration project;

"(iii) the extent to which health services for Indians will be enhanced as a result of the demonstration project;

"(iv) whether the project will provide new or expanded services within the existing health care delivery system, including, but not limited to, service such as home-based care or swing-bed services;

"(v) the combined Indian/non-Indian patient workload in the project service area, specifically with reference to average daily patient workloads and the impact of the project on improved quality of care;

"(vi) the economic viability of the proposed health care delivery or financing system and tribal administrative capability to provide the proposed services;

"(vii) a determination of the cost-benefit ratio of the project, taking into account the patient population workload and improvement in the quality of care;

"(viii) improved Indian patient access to health care resources and the value of such access in relation to Federal funding and the overall health benefits to the Indian tribe;

"(ix) identification of barriers to use of state resources;

"(x) how the project will integrate with area facility master plans, other national and area strategies for eliminating health deficiencies in accordance with this Act and how the project brings about an improvement in the level of need funded under this Act;

"(xi) whether health care services for the Indian community be served will be impaired or diminished by the proposed project; and

"(xii) the ability of the Department of Health and Human Services to support functions of the Department that are related to the demonstration project.

"(f) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this Act.

"(g) BRANCH OF HEALTH CARE DELIVERY DEMONSTRATION PROGRAMS.—The Secretary shall establish, within the Indian Health Service, a Branch of Health Care Delivery Demonstration Programs within the Office of Health Programs to oversee the demonstration projects established under this Act and to coordinate the provision of technical assistance to applicants and grantees.

"(h) SERVICE TO INELIGIBLE PERSONS.—The authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-Service health care practitioners as provided in section 713 of this Act may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

"(i) REPORT TO CONGRESS.—(1) Within 90 days after the end of the period set out in subsection (c), the Secretary shall, in consultation with tribes involved in approved demonstration projects, prepare and submit to Congress a report, together with legislative recommendations, on the findings and conclusions derived from the demonstration projects.

"(2) In addition, the report shall notify the Congress of the Secretary's intention to make permanent, discontinue, or substantially modify each of the demonstration projects. Congress shall have one year to respond before the Secretary takes action to modify or discontinue any of such projects.

"(j) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out the provisions of this section, there are authorized to be appropriated such sums as may be necessary."

TITLE III—URBAN HEALTH AMENDMENTS

SEC. 301. PRIORITY FOR FUND EXPENDITURES.

It is the intent of Congress that the priority for the expenditure of funds to be made available pursuant to this title shall be in accordance with the intent of sec-

tion 503(a) of the Indian Health Care Improvement Act with respect to access to existing resources and the provision of direct care.

SEC. 302. HEALTH CARE SERVICES FOR URBAN INDIANS.

(a) **HEALTH PROMOTION AND DISEASE PREVENTION.**—Section 503 of title V is amended by adding at the end the following new subsection:

“(c)(1) The Secretary, acting through the Service, shall facilitate access to, or provide, health promotion and disease prevention services as defined in section 4(k) and (1) of this Act for urban Indians through grants made to organizations administering contracts entered into pursuant to this section.

“(2) There is authorized to be appropriated \$1,000,000 for each of the fiscal years 1992, 1993, and 1994 to carry out this subsection.”.

(b) **IMMUNIZATION.**—Section 503, as amended by subsection (b) is further amended by adding at the end the following new subsection:

“(d)(1) The Secretary, acting through the Service, shall facilitate access to, or provide, immunization and immunization services for urban Indians through grants made to organizations administering contracts entered into pursuant to this section. Funds may be available pursuant to this subsection—

“(A) for printing and disseminating educational or other materials related to immunization services;

“(B) for the purchase of vaccines and other supplies needed to provide immunization services to patient populations, particularly infants, children, and the elderly; and

“(C) to provide personnel to deliver immunization services.

“(2) In making grants to carry out this subsection, the Secretary shall take into consideration—

“(A) the size of the urban Indian population to be served;

“(B) immunization levels of patient population, particularly infants, children, and the elderly;

“(C) the availability of alternative resources from State and local governments for no-cost or low-cost immunization services to the general population and factors related to the utilization patterns of these services by urban Indians; and

“(D) the capability of the urban Indian organization to carry out services pursuant to this subsection.

“(3) There is authorized to be appropriated \$1,000,000 for each of the fiscal years 1992, 1993, and 1994 to carry out this subsection.”.

(c) **MENTAL HEALTH SERVICES.**—Section 503, as amended by subsections (a) and (b), is further amended by adding at the end the following new subsection:

“(e)(1) The Secretary, acting through the Service, shall facilitate access to, or provide, mental health services for urban Indians through grants made to organizations administering contracts entered into pursuant to this section.

“(2) The Secretary may make such grants—

“(A) to conduct a mental health needs assessment of urban Indian communities to assess the mental health needs of the community, available resources, barriers to accessing those resources, and gaps in services; and

“(B) to develop a plan to improve those services.

“(3) Where an urban Indian organization has conducted a needs assessment as provided in paragraph (2) or where the Secretary has determined such organization has already developed such an assessment, the Secretary may make a grant to such organization—

“(A) to provide outreach, educational, and referral services to urban Indians to provide a linkage to available direct mental health services, educate the urban Indian community about mental health issues and services, and network with existing mental health providers to improve services to Indians;

“(B) to provide outpatient mental health services, including identification and assessment of illness, therapeutic treatment, case management, support groups, family treatment, and other treatment; and

“(C) to develop innovative mental health service delivery models which incorporate Indian cultural support systems and resources.

“(3) There is authorized to be appropriated \$2,000,000 for fiscal year 1992, \$3,500,000 for fiscal year 1993, and \$5,000,000 for fiscal year 1994 to carry out this subsection.”.

(d) **PREVENTION AND TREATMENT OF CHILD ABUSE.**—Section 503, as amended by subsections (a), (b) and (c), is further amended by adding at the end of the following new subsection:

"(f)(1) The Secretary, acting through the Service, shall facilitate access to, or provide, services for urban Indians through grants to organizations administering contracts entered into pursuant to this section to prevent and treat child abuse (including sexual abuse) in urban Indian communities. Funds may be made available pursuant to this subsection—

"(A) to conduct a needs assessment as required by paragraph (2)(C) of this subsection;

"(B) for the development of prevention, training and education programs for urban Indian communities, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection; and

"(C) to provide direct outpatient treatment services in Indian urban communities (including individual treatment, family treatment, group therapy, and support groups) to child victims of abuse (including sexual abuse), adult survivors of child sexual abuse, families of child victims, and perpetrators of child abuse (including sexual abuse).

"(2) In making grants to carry out this subsection, the Secretary shall take into consideration—

"(A) the support for the urban Indian organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act (25 U.S.C. 1901 *et seq.*), if any;

"(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

"(C) a needs assessment, submitted by the urban Indian organization before requesting funding under this subsection, which documents the prevalence of child abuse in the Indian community and the proposed services which do not duplicate existing services and which are approved by the Service.

"(3) There is authorized to be appropriated \$2,000,000 for fiscal year 1992, \$3,500,000 for fiscal year 1993, and \$5,000,000 for fiscal year 1994 to carry out this subsection."

(e) FACILITIES ASSESSMENT.—Section 503, as amended by subsections (a), (b), (c), and (d), is further amended by adding at the end the following new subsection:

"(g)(1) The Secretary shall conduct a survey of all facilities used by a contractor under this title and shall submit a report to the Congress on such survey one year after the date of enactment of this subsection. The report shall, at a minimum, contain the following information for each location—

"(A) the extent to which the facility meets life safety and building codes and, if direct care is provided, the extent of compliance with Joint Commission for Accreditation of Health Care Organizations (JCAHO) standards;

"(B) the extent to which improvements, expansion, or relocation is necessary to meet program requirements, provide adequate services, or achieve building code compliance;

"(C) any lease restrictions that would hamper accomplishment of needed improvement, expansion, or relocation;

"(D) the term of the lease, if appropriate, the age of the structure, and the structure's life expectancy with and without improvement; and

"(E) site specific overall assessments.

"(2) The report shall contain general recommendations for addressing the deficiencies of facilities in which programs funded under this title are located and shall propose specific program policies for accomplishing those recommendations.

"(3) The Secretary may make funds available to contractors under this title for minor renovations to facilities, including leased facilities, to assist such contractors in meeting or maintaining JCAHO standards and there is hereby authorized to be appropriated \$1,000,000 for fiscal year 1992, \$1,500,000 for fiscal year 1993, and \$2,000,000 for fiscal year 1994 for that purpose."

SEC. 303. REPORTS.

Section 507 of title V is amended by adding at the end the following new subsection:

"(d)(1) The Secretary, acting through the Service, shall submit a report to the Congress in March of 1992, 1993, and 1994 evaluating—

"(A) the health status of Indians in urban areas;

"(B) the services provided to Indians through this title; and

"(C) areas of unmet need, including urban areas not served pursuant to this Act.

"(2) In preparing the report under paragraph (1), the Secretary shall consult with urban Indian health providers and may contract with a national organization representing urban Indian health concerns to conduct any aspect of the report.

"(3) The Secretary and the Secretary of the Interior shall report to Congress no later than March 1992 their assessment of the status of Indian child welfare in urban communities, including information as to the volume of child protection cases, the prevalence of child sexual abuse, the extent of urban coordination with tribal authorities, and their legislative recommendations to improve Indian child protections in urban communities."

SEC. 304. URBAN HEALTH PROGRAMS BRANCH.

Title V is amended by adding at the end the following new section:

"URBAN HEALTH PROGRAMS BRANCH

"SEC. 509. (a) There is hereby established within the Office of Health Programs of the Indian Health Service, as a part of the Division of Clinical and Preventive Services, a Branch of Urban Health Programs which shall be responsible for carrying out the provisions of this title.

"(b) The Secretary shall appoint such employees to work in the Branch, including a Program Director, and shall provide such services and equipment as may be necessary for it to carry out its responsibilities. The Secretary shall also analyze the need to provide at least one urban health program analyst for each area office of the Indian Health Service and shall submit his findings to the Congress as a part of the Department's fiscal year 1993 budget request."

TITLE IV—MISCELLANEOUS

SEC. 401. ALASKA RESIDENTIAL YOUTH TREATMENT CENTER.

(a) AMENDMENT.—Section 4227(b) of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2474(b)) is amended by adding at the end thereof the following:

"(3) Notwithstanding any other provision of this subtitle, the Secretary may, from amounts authorized to be appropriated pursuant to this section, make funds available to the Tanana Chiefs Conference, Incorporated, for the purpose of maintaining a residential youth treatment facility in Fairbanks, Alaska."

(b) LEASE OF FACILITIES.—The Secretary of Health and Human Services, acting under section 4209(c) and 4227(b) of the Indian Alcohol and Substance Abuse Prevention and Treatment Act, may—

(1) without regard to section 4209(c)(2) of that Act, lease from the Tanana Chiefs Conference facilities that are located in Fairbanks, Alaska, and that the Tanana Chiefs Conference has leased from another entity, and

(2) if the Secretary enters into a lease under paragraph (1) for at least 40 years, renovate the facilities to the extent needed.

(c) SELF-DETERMINATION CONTRACTS FOR STAFFING AND OPERATION.—The Secretary of Health and Human Services, acting under section 102 of the Indian Self-Determination and Education Assistance Act, may contract with the Tanana Chiefs Conference to staff and operate the facilities leased under subsection (b), without a request of an Indian tribe, and without regard to the definition and proviso in section 4(l) of that Act.

PURPOSE

The purpose of S. 1270 is to authorize the Secretary of Health and Human Services to establish within the Indian Health Service a program to make grants to Indian tribes and intertribal consortia to plan, develop, and implement mental health demonstration projects.

BACKGROUND

For the first half of the 20th century, Indian health care was provided by the Department of the Interior. In 1955, the responsibility for health services was transferred from the Department of the Interior to the Department of Health, Education and Welfare. It was

at that time, that the Indian Health Service (IHS) was also established.

In the early years of IHS, mental health services were provided only sporadically. It wasn't until 1965 that an Office of Mental Health was established within the Indian Health Service and services began to improve. The early mental health programs focused on training of local tribal members in providing community mental health services. Over the years, the IHS mental health services have evolved to include outpatient services.

Currently, the IHS is divided administratively into 12 Area offices, each of which has a full or part-time mental health consultant. The Area offices serve to allocate mental health funds to the Service Units or Tribal programs. There are about 127 Service Units which are currently operated by IHS or by a tribe. The Service Units are responsible for direct delivery of health and mental health services.

Two laws have had a significant impact on the IHS mental health program. The Indian Self-Determination and Education Assistance Act, (P.L. 93-638) was enacted in 1975. This law enables Indian tribes to contract with IHS for the management and operation of their own health and mental health programs. The Indian Health Care Improvement Act, (P.L. 94-437) was enacted in 1976 and amended in 1988. This law, as amended, authorized additional funding for the expansion of health and mental health services, construction and renovation of medical facilities, initiatives to increase Indian health professionals, and improvements in the area of urban Indian health care.

Of the total Indian Health Service budget of \$1 billion in FY '90, the mental health program receives only \$21.5 million. These funds supported a total of about 335 mental health staff. Epidemiological studies in 1988 suggested that the current IHS mental health staff levels are less than half of what they should be. The IHS Resource Requirement Methodology (RRM) standard suggests that there should be at least one professional staff for every 2,000 population in order to provide a minimum level of ambulatory care. Using the total population base of 1,016,815 (IHS estimate) at least 508 professionals would be needed to serve the current Native American population.

While the causes of mental health problems are not known with certainty, it is thought that many life situations on Indian reservations can contribute to emotional distress and serious mental health problems in the Indian population. Studies on depression and emotional problems in Native American communities are thought to be related to factors such as poverty, unemployment, geographic isolation and lack of cultural identity. Other factors which contribute to the increased incidence of mental and behavioral problems include physical and sexual abuse, neglect, parental alcoholism, family disruption and poor school environments.

While life situations can be a major contributing factor in the incidence of depression among Indian people, alcohol and drug abuse frequently complicate existing emotional problems. Mental retardation and developmental disabilities have increased with the prevalence of long-term alcohol abuse in Indian communities. It has only been recently that we are understanding the seriousness of fetal al-

cohol syndrome and its consequences particularly in Indian communities.

The combination of low self-esteem and alcohol abuse often are contributing factors in the occurrence of violent behavior such as child, spouse, or elder abuse, homicide, and suicide occurring on Indian reservations. The Indian Health Service's "National Plan for Native American Mental Health Services" relates some astonishing statistics. For instance, the suicide rate among Native Americans is higher than the general population. Suicide is the second leading cause of death for American Indian and Alaska Native Adolescents. In 1986, the suicide rate for Indian youth between the ages of 15 and 19 was estimated at 26.3 deaths per 100,000 population. In comparison, the figures for the same age group for all races in the U.S. was 10.0 per 100,000. Suicide deaths for Indian youth 10 to 14 years old are approximately four times higher than the national population.

It is clear from the data available that the current system for treating mental health in Indian country is not adequate. Accessibility and availability of services are limited and often the services that are available aren't meeting the needs of Indian people. Most IHS or tribal operations provide limited access to partial hospitalization and transitional living or child residential mental health programs. In most cases, these services are contracted from local or state resources. However, as noted by IHS, Native Americans often do not use state or local services because providers of these services are not often culturally sensitive to Indian people.

There are also serious shortages in the area of mental health care providers. The OTA report asserts that the ratio of providers to population is below standards. In 1989, IHS funded 236 mental health positions. Of these, 198 are direct treatment staff. The remaining staff are administrative or clerical. Service unit direct care staff includes 45 mental health technicians, 52 social workers, 37 psychologists, and 22 psychiatrists. The resources necessary to cope effectively with the serious problems of mental illness on Indian reservations are clearly inadequate. This deficiency is particularly apparent for children and adolescents who comprise 43 percent of the service population. In 1989, IHS reported that there are only 17 mental health providers trained to treat children and adolescents. The recommended ratio of psychiatrists to children is between 4 and 5 mental health providers to every 10,000. If IHS followed this standard, it would have to expand its current providers to approximately 200.

The scarcity of staff seems to be due to a combination of the widespread need and the fact that funding for IHS health care has not kept up with the need or inflation. To compound the problem, IHS has had difficulty in recruiting clinical personnel to IHS service areas. Congress has tried to address some of these shortcomings in the recent Indian Health Care Act amendments. However, the full authorizations have never been requested by IHS or appropriated by Congress.

Based on the hearing record and testimony several options have been identified by Indian Tribes, OTA and Indian Health Service. Many of these suggestions have been incorporated into the substi-

tute amendment discussed later in this report. The following is a summary of those options:

OTA Report suggests several options for Congress to consider—

Increase resources for mental health services within IHS. The report notes that twice the funding is needed and that staffing resources should also be increased;

Target funding to Indian adolescents. Services are currently almost non-existent;

Provide a specific level of mental health professionals in each service unit.

Provide training to non-mental health professionals.

Address manpower shortages. OTA suggests that a portion of available funds should be specially targeted to students who work with adolescents.

The Indian Health Service developed a National Mental Health Plan for American Indians/Alaska Natives which incorporates Indian Health Service, tribal and National Indian Organizations views of how to best meet the mental health needs of the Indian population. The National plan includes the following:

Increasing the current number of direct treatment staff;

Provide culturally relevant training to current staff;

Improve coordination among federal, state, local and Tribal mental health and related agencies and personnel;

Encourage community involvement in combatting self-destructive behaviors;

Improve recruitment and retention of mental health professionals; and

Expand the existing provision in the Indian Health Care Improvement Act with respect to retention bonuses, and place a priority on mental health professionals.

COMMITTEE AMENDMENT

The Select Committee on Indian Affairs conducted a hearing on S. 1270 on September 14, 1989. During that hearing, witnesses described the difficulty of effectively meeting the mental health needs of their people. Many of the witnesses expressed their support for a more flexible approach such as those provided in S. 1270. The Indian Health Service on the other hand, defended its current approach and expressed the need to build upon existing resources. On November 16, 1989, S. 1270 was passed by the Senate and was jointly referred to the Energy and Commerce and Interior and Insular Affairs Committees.

On March 29, 1990, the Committee on Interior and Insular Affairs conducted an oversight and legislative hearing on mental health needs in Indian country and on S. 1270. At that time, it became clear that there were serious deficiencies in the current Indian mental health services to Indian people. The Office of Technology Assessment presented its report, "Indian Adolescent Mental Health" which documents that mental health services for adolescents are inadequate. Comparative data in that report suggests that, in general, Indian adolescents have more serious mental health problems than any other race in the U.S. population. In addition to the OTA report, the Indian Health Service presented tes-

timony outlining major recommendations to improve mental health services to Indian people. Based on that hearing, the Committee conducted two field hearings in Seattle, Washington and Rapid City, South Dakota. While there was general support for S. 1270 and the creation of mental health demonstration programs, many Tribes were concerned that the demonstration approach set forth in S. 1270 would only benefit a few. There seemed to be a general consensus that any effort to improve mental health services should be addressed in a comprehensive manner and should include resources in staffing and recruitment and retention, mental health training and community education, and research.

On September 29, 1990 the Committee adopted an amendment in the nature of a substitute to S. 1270. The substitute amends Titles II and IV of the Indian Health Care Improvement Act (IHCIA) and establishes the following:

Title I of the substitute amends title II of the IHCIA to add a new section for comprehensive mental health services. The new section authorizes IHS to develop mental health prevention and treatment programs building on existing programs and authorities in the areas of education, family and social services, law enforcement, judicial and health services. In addition, it requires IHS to provide direction and guidance to those Federal agencies and tribal and local health providers responsible for Indian programs. It provides for the development and implementation of tribal community based mental health programs.

Title II amends title III of the IHCIA adding a new section which provides for Indian Health Care Delivery Demonstration Projects. On March 22, 1990, the Senate Select Committee on Indian Affairs conducted an oversight hearing on the Indian health care delivery system and the feasibility of considering alternative resources. Over the past several years, recommendations have come forward to close or dramatically alter existing IHS facilities in favor of consolidating services or replacing an existing facility with one which offers a scaled down level of services. The increasing trend toward small rural hospital closures has prompted consideration of innovative approaches which ensure that access to health care is not compromised.

The purpose of the hearing was to examine two issues. First, whether the types of health care facilities being considered for construction in rural areas ought to be expanded beyond those of a full-blown inpatient hospital. Second, the consideration of alternative resources which could include non-IHS dollars being used for construction of health care facilities. The issue of rural facility closures and the need to assess the potential for cost efficient care through community-based facilities rather than IHS facilities is an issue which has been reviewed and studied by GAO. In particular, the GAO reviewed the factors that contributed to the low utilization of inpatient services of nine small IHS hospitals and evaluated whether other cost-effective alternatives existed. The report recommended discontinuing inpatient services at nine facilities. IHS responded to his report by establishing new standards for construction of inpatient facilities based on average daily patient load. The impact of this new policy would have resulted in the closure of

many isolated, rural facilities and severely limited access to general health care.

The existing IHS facilities construction priority system is numbers driven. Many of the smaller Indian tribes with low patient workload would never meet the current requirements imposed by IHS and, therefore, they would never be placed on the construction priority list.

In response to the new standards proposed by IHS, Senator John McCain introduced S. 2850. This bill authorizes health care delivery demonstration projects which allow tribes to design and implement innovative approaches for the delivery of cost effective health care. S. 2850 encourages the use of existing IHS health care facilities, resources and funds; allows the use of non-IHS funds for construction of IHS or tribal health care facilities; and provides the flexibility to enter into agreements involving IHS, tribal, state and local governments to pool resources to provide services to Indians and non-Indians in rural communities. The amendment in nature of the substitute to S. 1270 incorporates a revised text of S. 2850 as Title II.

Title III of the substitute amendment incorporates the modified text of H.R. 5000, the Urban Indian Health Act. H.R. 5005 amends Title V of the Indian Health Care Improvement Act to improve the health status of the urban Indian population and to enhance the quality and scope of health care services, disease prevention and health promotion. Title V of the Indian Health Care Improvement Act currently includes minimal services to urban Indians. The primary focus of the Act has been for the health care of Indian people residing on reservations. Recent U.S. Census data indicates that over 50 percent of the 1.4 million American Indian population resides in urban areas. In addition, less than 1% of the total IHS Budget goes to address the health care needs of the urban Indian population.

Currently there are 35 urban Indian health programs throughout the United States which receive funding under Title V of the Indian Health Care Improvement Act. While many of these programs meet the basic health care needs for Indians in urban settings who would otherwise not receive care, the effect of rising medical cost has diminished the overall purchasing power of urban Indian programs. While the overall IHS budget has experienced slight increase of about 2% for adjustment of inflation, the urban Indian Health Program has actually experienced a net loss of approximately 70 percent. The impact of decreased funding has left the urban programs unable to respond to the growth in urban Indian populations and their demand for health services.

This legislation would expand the level of care to provide health promotion and disease prevention services; immunizations initiatives for infants and children; mental health services; child abuse (including sexual abuse) prevention and treatment services; provides for a facilities improvement fund, as well as requiring the Indian Health Service and the Department of Interior to report to Congress as to the status of urban Indian health. In addition, the bill authorizes new funding levels for each of the new sections which will bring health care services provided to urban Indians up to a level comparable with the Indian Health Service system.

Title IV of the bill contains a miscellaneous section which amends Section 4227(b) of the Indian Alcohol and Substance Abuse and Treatment Act of 1986 to provide for an Alaskan Residential Youth Treatment Center.

A more detailed explanation of the Substitute is set out in the section-by-section analysis.

SECTION-BY-SECTION ANALYSIS

The Committee adopted an amendment in the nature of a substitute. A section-by-section analysis of the bill, as amended, follows:

Section 1

Section 1 provides that the act may be cited as the "Indian Health Care Amendments of 1990".

Section 2

Section 2 provides that, unless otherwise stated, amendments made by the bill are considered to be made to the Indian Health Care Improvement Act (25 U.S.C. 1601 *et seq.*).

TITLE I—MENTAL HEALTH SERVICES

Section 101

Section 101 amends title II of the Indian Health Care Improvement Act by adding a new section 208 relating to mental health prevention and treatment.

Subsection (a) sets out the purpose of the section to provide for the establishment of a comprehensive mental health prevention and treatment program to be implemented by, or through, the Indian Health Service.

Subsection (b) requires the Secretary of Health and Human Services (Secretary), acting through the Indian Health Service (Service), to develop and publish a National Plan for Indian mental health services within 120 days after enactment which will assess the scope of mental problems among Indian people, the existing and needed resources necessary to support a mental health program, and the amount of funds necessary to support such a program. The report is to be submitted to the Congress.

Subsection (c) requires the Secretary and the Secretary of the Interior to develop and enter into a Memorandum of Agreement on the programs and responsibilities of the two Secretaries in the area of Indian mental health and delineates the minimum points of agreement and consideration which must be included in the MOA.

Subsection (d) authorizes any Indian tribe, or consortium of tribes, to provide for the establishment of a Community Mental Health Plan for its members as a basis for the implementation of this section and the MOA under subsection (c) within its reservation. Appropriate officials of the Bureau of Indian Affairs and the Service are required to assist the tribes in the development of such plan and to enter into an agreement with the tribe for its implementation. Finally, it provides that the Secretary may make grants to the tribes to assist in the development and implementation of such a plan and authorizes \$1,000,000 for FY 1992, 1993, and 1994 for such grants.

Subsection (e), paragraph (1), requires the two Secretaries to compile a list of staff positions maintained by the Bureau of Indian Affairs and Service, and similar positions maintained by Indian tribes under the Indian Self-Determination Act, the qualifications of which should include training relating to mental health problems.

Paragraph (2) provides that the two Secretaries shall provide training to their employees as identified pursuant to paragraph (1) and either provide such training, or provide funds to tribes to provide such training, to tribal employees identified pursuant to paragraph (1) of others identified as needing such training.

Paragraph (30) provides that any position-specific training developed pursuant to this subsection shall be consistent with any national standards for such training, but shall also adopt and apply training methods culturally relevant to Indian communities, including, where appropriate, traditional Indian mental health healing methods.

Paragraph (4) provides that the Service shall develop, or assist Indian tribes in developing, a program of community education on mental health problems for Indian communities and shall provide tribes with technical assistance in developing materials for such education.

Paragraph (5) authorizes the appropriation of \$5,000,000 for FY 1992, 1993, and 1994 to carry out the subsection, including \$1,200,000 for paragraph (4).

Subsection (f) directs the Secretary to develop a plan under which the staff of the Service devoted to mental health care shall be increased by at least 500 positions in five years, with at least 200 of such positions assigned to child, adolescent, and family services. Implementation of the plan is to be as authorized under the Snyder Act (25 U.S.C. 13).

Subsection (g) provides that the Secretary shall take steps to enhance the ability of the Service to recruit and retain mental health care officials through existing scholarship and manpower provisions and through special efforts for bonuses, loan repayment, and postgraduate rotations. It authorizes the appropriation of \$1,200,000 for each of the fiscal years 1992, 1993, and 1994 for such purposes.

Subsection (h) provides that the Secretary shall establish and maintain a Mental Health Technician program within the services for the training and employment of Indians to provide community services as mental health technicians, including the utilization of traditional mental health care practices. It authorizes the appropriation of \$1,000,000 for training costs under the subsection.

Subsection (i) authorizes the Secretary to enter into contracts with appropriate institutions to conduct research relating to the incidence and prevalence of mental health disorders among Indians and authorizes the appropriation of \$2,000,000 for such purpose.

Subsection (j) requires the Secretary to make an assessment of the need for, and availability and cost of, inpatient mental health facilities to serve Indian needs and authorizes the appropriation of \$500,000 to make this assessment.

Subsection (k) requires the Secretary to make an annual report to Congress on the status of mental health programs for Indians and progress made in meeting their mental health needs.

Subsection (1), paragraph (1), provides that the Secretary is authorized to make at least five grants to Indian tribes or tribal consortia to pay 75% of the cost of a mental health demonstration grant program to deliver mental health services to its members through innovative and community-based means. It provides that the 25% tribal share may be met through cash or in-kind contributions.

Paragraph (2) provides that the Secretary, in selecting applications for approval, shall ensure that grant proposals are not duplicative of each other in their scope and nature. It also provides other factors to be taken into consideration by the Secretary in approving such applications.

Paragraph (3), (4) and (5) set out the information which must be included in any application submitted for a grant under this subsection; set a limit of \$1,000,000 on the amount of any such grant; and requires the Secretary to establish regulations for the submission, review and approval of such applications.

Paragraph (6) requires the Secretary to submit to the Congress, within 180 days of the end of the last grant made, to the Congress evaluating such demonstration projects and making appropriate recommendations.

Paragraph (7) authorizes the appropriation of \$3,000,000 for each of the fiscal years 1992, 1993, and 1994.

TITLE II—HEALTH CARE DELIVERY

Section 201

Subsection (a) amends section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603) by adding at the end thereof a new subsection (m) defining the term "Health Care Delivery Demonstration Project". The term is defined as a project approved by the Secretary pursuant to section 307 of the Act to support the design and implementation of innovative approaches for the delivery of cost effective health care to Indians which do not replicate existing models of the Service and which adopt innovative uses of funds, facilities, and resources to provide such care.

Subsection (b) amends title III of the Indian Health Care Improvement Act by adding a new section 307, providing for the establishment of an Indian Health Care Delivery Demonstration Project program.

Subsection (a) contains congressional findings relating to the responsibility of the United States to provide health care services to Indians and the inadequacies of existing programs.

Subsection (b) provides that the purpose of this section is to authorize innovative demonstration projects which allow Indian Tribes to devise alternative health care delivery systems using new and existing resources; enable tribes to develop innovative financing mechanisms; and enable tribes to utilize all available resources which may benefit both eligible and ineligible community members.

Subsection (c), paragraph (1), authorizes the Secretary, acting through the Service, to enter into contracts with, or make grants to, Indian tribes or tribal organizations for the purpose of carrying out Health Care Delivery Demonstration Projects.

Paragraph (2), provides that, in approving projects under this section, the Secretary may authorize funding for health facilities construction and renovation and may also waive leasing prohibitions, permit carryover of funds, permit the use of non-service funds and non-federal funds, and permit the use and reversion of donated property.

Paragraph (3) requires the Secretary, in approving applications for the demonstration projects, to provide for a fair geographic distribution of such projects among tribes and select for consideration and approval proposals which involve (A) funds from other sources; (B) funds from the Service of not less than 25 percent and not more than 75 percent of the total cost and (C) involve 100 percent IHS funding, with at least one in each category being approved, if possible.

Paragraph (4) provides that the Secretary shall approve demonstration projects in at least the nine identified service units of the Indian Health Service subject to availability of funds and the submission of an application by the tribe or tribes served by such service unit which meets the requirements of this section.

Paragraph (5) states that eligibility should not be based solely on the financial resources of the tribe or organization.

Subsection (d) requires the Indian tribe or tribal organization to submit an application which shall be in such form as the Secretary prescribes and which shall include an assessment of the existing health care resources and needs and a description of the proposal for any new or innovative health care delivery system to be operated and tested.

Subsection (e), paragraph (1), requires the Secretary to publish in the Federal Register within 180 days after enactment, a copy of the proposed criteria for the review and approval of applications for the demonstration projects. A copy of the criteria shall also be submitted to the Senate Select Committee on Indian Affairs and the House Committee on Interior and Insular Affairs and the House Committee on Energy and Commerce.

Paragraph (2) provides that the criteria established under paragraph (1) shall include a peer review panel to review, evaluate and rank the applications; establishes membership requirements for such panel; and outlines the criteria the review panel shall take into consideration when reviewing the applications.

Subsection (f) requires the Secretary to provide technical assistance to the applicants.

Subsection (g) establishes within the Service a branch of Health Care Delivery Demonstration Programs to oversee the demonstration projects and to coordinate technical assistance to the applicants and grantees.

Subsection (h) provides that the authority to extend services to persons otherwise ineligible for Indian Health services contained in section 713 of the Act shall be made a part of any project funded under this section.

Subsection (i) provides that the Secretary, in consultation with Indian tribes, shall prepare and submit a report to Congress within 90 days after the end of the period set out in subsection (c) and requires that, at the conclusion of the project, the Secretary shall

make recommendations to Congress as to whether the demonstration projects should be made permanent or discontinued.

Subsection (j) authorizes such sums as necessary to carry out the provisions of the section.

TITLE III—URBAN INDIAN HEALTH CARE

Section 301

Section 301 expresses the intent of Congress that the priority for the expenditures of funds made available by this title shall be in accord with the priorities established in section 503(a) of title V of the Indian Health Care Improvement Act which requires that urban Indian health care funds be used first to assist urban Indians in accessing existing health care services before the provision of direct services under the contract.

Section 302

Subsection (a) amends section 503 of title V of the Indian Health Care Improvement Act by adding a new subsection (c) at the end thereof which provides that the Secretary, acting through the Service, may make grants to Indian organizations administering contracts under title V to facilitate access to, or provide, health promotion and disease prevention services to urban Indians. For each of the fiscal years 1992, 1993, and 1994, \$1,000,000 is authorized.

Subsection (b) further amends section 503 by adding a new subsection (d) at the end thereof which provides that the Secretary, acting through the Service, may make grants to title V contractors to facilitate access to, or provide immunizations and immunization services for urban Indians with grant funds to be available for educational materials, purchase of vaccines and other supplies necessary for such services, and personnel. It also establishes factors for the Secretary to take into consideration in approving grants and authorizes the appropriation of \$1,000,000 for each of the fiscal years 1992, 1993, and 1994 for such grants.

Subsection (c) further amends section 503 by adding a new subsection (e) which provides that the Secretary, acting through the Service, may make grants to title V contractors to facilitate access to, or provide, mental health services to urban Indians by conducting a mental health needs assessment for the urban Indian community and for developing a plan to improve available services. It provides that, where such a needs assessment has been done or where the contractor has otherwise developed the necessary information, the Secretary may make grants to the contractor to ensure that the needed mental health services are available and accessible or are provided under the grant. It authorizes the appropriation of \$2,000,000 in FY1992, \$3,500,000 in FY1993, and \$5,000,000 in FY1994.

Subsection (d) further amends section 503 by adding a new subsection (f) at the end thereof which provides that the Secretary, acting through the Service, may make grants to title V contractors to facilitate access to, or provide, services to urban Indians for the prevention and treatment of child abuse with funds under the grant to be available for a needs assessment, for development of prevention, training and education programs for urban Indian com-

munities, and to provide direct outpatient treatment services. It sets out factors the Secretary should take into consideration in considering and approving grant application and authorizes the appropriation of \$2,000,000 for FY1992, \$3,500,000 for FY1993, and \$5,000,000 for FY1994.

Subsection (e) further amends section 503 by adding a new subsection (g) at the end thereof which provides that the Secretary shall conduct a survey of, and submit to the Congress a report on, facilities used by title V contractors. It sets out the type of information which should be contained in the report and provides that it shall contain the Secretary's general recommendations relating to those facilities. It authorizes the appropriation of \$1,000,000 in FY1992, \$1,500,000 in FY1993, and \$2,000,000 in FY1994 for the Secretary to make grants to title V contractors to make minor renovations in existing facilities to comply with Joint Commission for Accreditation of Health Care Organizations standards.

Section 303

Section 303 amends section 507 of title V of the Indian Health Care Improvement Act by adding a new subsection (d) at the end thereof which requires the Secretary, acting through the Service, to submit a report to Congress in March of 1992, 1993, and 1994 on the health status, health services and unmet health care needs relating to urban Indians. It also requires the Secretary, in cooperation with the Secretary of the Interior, to submit a report to Congress by March 1992 on the status of Indian child welfare in urban communities.

Section 304

Section 304 amends title V of the Act by adding a new section 508 at the end thereof which provides for the establishment and staffing of a Branch of Urban Health Programs in the Indian Health Service.

TITLE IV—MISCELLANEOUS

Section 401

Section 401 amends section 4227(b) of the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2474(b)) by adding a new paragraph (3) which provides that the Secretary may make funds available, from funds appropriated pursuant to the section, to maintain a residential youth treatment center in Fairbanks, Alaska.

The Indian Health Service has designated two locations in Alaska for youth regional treatment centers and this designation is concurred in by the Alaska Native Health Board. One center will be in Sitka operated by the Southeast Alaska Regional Health Corporation (SEARHC) and one will be in Fairbanks operated by Tanana Chiefs Conference, Incorporated (TCC). These entities are sharing the allocation of funds made to the Alaska Area for a youth treatment facility. The provisions in title IV clarify the authority of the Indian Health Service to provide funds for these purposes.

COST AND BUDGET ACT COMPLIANCE

The cost analysis prepared by the Congressional Budget Office is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 3, 1990.

HON. MORRIS K. UDALL,
Chairman, Committee on Interior and Insular Affairs, House of
Representative, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for S. 1270, the Indian Health Care Amendments of 1990, as ordered reported by the House Committee on Interior and Insular Affairs on September 19, 1990.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER,
Director.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: S. 1270.
2. Bill title: Indian Health Care Amendments of 1990.
3. Bill status: As ordered reported by the House Committee on Interior and Insular Affairs on September 19, 1990.
4. Bill purpose: To provide mental health services to Indians, to improve the health status of the urban Indian population, and to establish innovative demonstration projects that would provide health services to Indians.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1991	1992	1993	1994	1995
Estimated authorization levels					
Mental health services:					
Community plans		1	1	1	
Training and education		5	5	5	
Mental health staff recruitment		1	1	1	
Technician training		1			
Research		2			
Facilities assessment		1			
Demonstrations		3	3	3	
Mental health staff employment		6	11	18	24
Technician employment		1	1	1	1
Report	(1)	(1)	(1)	(1)	(1)
Urban Indian health initiatives:					
Health promotion		1	1	1	
Immunization		1	1	1	
Mental health services		2	4	5	
Child abuse prevention		2	4	5	
Facilities assessment		1	2	2	
Reports		1	(1)	(1)	
Urban health branch	(1)	(1)	1	1	1
Innovative health care delivery demonstrations	(2)	(2)	(2)	(2)	(2)

[By fiscal years, in millions of dollars]

	1991	1992	1993	1994	1995
Total:					
Estimated authorization levels ³	11	31	41	50	33
Estimated outlays ³	9	26	38	48	36
.....					

¹ Less than \$500,000.² The costs of these demonstrations depend on a number of factors and are very uncertain. See the discussion below.³ Totals do not include the innovative health care delivery demonstrations provision.

Note.—Details in the table may not add to totals because of rounding.

The costs of this bill fall within budget function 550.

Basis of Estimate: S. 1270 would authorize federal funds to provide mental health services to Indians, improve the health of Indians living in urban areas, and to establish demonstrations that would provide health care services to Indians in an innovative manner. This estimate assumes that all authorizations are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of recent program data.

Mental Health Services: The bill would authorize federal funds to: assist Indian tribes to develop and administer a community mental health plan; provide relevant training and community education on mental illness and dysfunctional behavior; recruit mental health professionals; train mental health technicians; research mental disorders among Indian populations; assess the need and cost of inpatient mental health facilities; and make at least five demonstration grants to Indian tribes to pay 75 percent of the costs of planning and implementing mental health service programs. The recipients of the demonstration grants would have to provide for the other 25 percent of the program costs. The bill specifies the authorization levels for these provisions.

In addition, the bill authorizes the Secretary of Health and Human Services (HHS), under the authority of the Snyder Act, to increase the mental health care staff by at least 500 positions within five years of enactment. Based on information provided by the Indian Health Service (IHS), CBO estimates that the average cost of salary and benefits for a mental health care profession is \$56,000 per year. CBO further assumed that IHS would increase its mental health care staff by adding 100 positions in each of fiscal years 1991 to 1995. Therefore, CBO estimates that this provision would cost about \$6 million in 1991, increasing to \$31 million in 1995.

S. 1270 also states that the Secretary of HHS shall, under the authority of the Snyder Act, employ additional health technicians. Based on information provided by IHS, CBO assumes that the average cost of salary and benefits for a mental health technician is about \$24,000 per year. CBO further assumed that IHS would add another 40 mental health technician positions in fiscal year 1991. Therefore, CBO estimates that this provision would cost approximately \$1 million in each year, 1991 to 1995.

The bill would require the Secretary of HHS to report on the mental health status of Indian people and the progress being made to address mental health problems of Indian communities each

year. CBO estimates that the reports would cost less than \$500,000 in each fiscal year.

Urban Indian Health Initiatives: The bill would authorize federal funds to provide health promotion and disease prevention services, immunizations, mental health services, and child abuse prevention and treatment services to urban Indians. In addition, the bill would authorize the Secretary of Health and Human Services (HHS) to conduct a survey of all urban health facilities affected by this legislation and to provide funds to those facilities that need minor renovations. Authorization levels for these provisions are specified in the bill.

S. 1270 would authorize the Secretary of HHS to report to Congress in March of 1992, 1993, and 1994 on the health status of Indians in urban areas. In addition, the bill would authorize the Secretary of HHS to report to Congress by March 1993 on the status of Indian Child welfare in urban communities. Based on information provided by the Indian Health Service (IHS), CBO estimates that the health status reports would cost \$250,000 per year, and that the Indian child welfare report would cost a total of \$400,000.

The bill would establish a Branch of Urban Health Programs within IHS. The Secretary of HHS would be required to analyze the need to provide one urban health program analyst in each of IHS's area offices and to submit his findings in the fiscal year 1993 budget request. Based on information provided by IHS, CBO estimates it would cost about \$250,000 in each of fiscal years 1991 and 1992 to establish and maintain a central branch, and \$500,000 in fiscal years 1993 to 1995 to maintain a central branch as well as support a urban health program analyst in each of the area offices.

Innovative Health Care Delivery Demonstrations: The bill would authorize the Secretary of HHS to establish between 9 and 35 demonstration projects to determine innovative and effective means of providing health facilities and services to Indian tribes outside of the IHS priority system. The type of demonstration projects that would be funded depend on future proposals and applications by Indian tribes. The possible costs of such projects range widely, from allowing Indian facilities to provide health services to non-Indian residents on a fee-for-service basis, which could have no net costs if fees were set high enough, to allowing tribes to construct new hospitals, which could cost several million dollars each. IHS would be responsible for fully funding a third of the projects that involve construction or renovation, funding up to 75 percent of the costs of another third, but would not be responsible for funding the remainder. Non-IHS funds could come from other federal agencies, states or local governments, or tribes.

CBO has assumed in estimating the cost of this provision that the new demonstration projects will be similar to the current Siletz project. This is because the Siletz demonstration project goals are nearly the same as those specified for the projects in this bill. For example, the Siletz clinic demonstration examines new ways of providing health facilities and services outside of the IHS priority funding process. The clinic provides ambulatory health services to Indians and to non-Indian residents on a fee-for-service basis. In total, the project cost \$851,000 in 1990. IHS appropriations for clinic equipment, basic utilities and 6 positions totaled \$470,000 in

fiscal year 1990. Funds for construction, totaling \$381,000, were obtained from non-IHS sources. Ten percent of the non-IHS funds were obtained from the tribal council, while 90 percent of the non-IHS funds came from two federal government agencies, the Bureau of Indian Affairs, and the Department of Housing and Urban Development.

If we assume that the demonstrations authorized by this bill are similar in scope and cost to the Siletz clinic demonstration, and, as in the Siletz case, that federal government agencies would provide 90 percent of the non-IHS funding, then each demonstration would cost the federal government an average of \$820,000 in the first year, and about \$220,000 in each of the following years. The Secretary of HHS would have 5 years after the date of enactment to establish these demonstrations. While it is uncertain when these costs would be incurred, CBO has assumed that one-fifth of the projects would be initially funded in each fiscal year, 1991 to 1995. Therefore, this provision could cost between \$2 million and \$6 million in fiscal year 1991, increasing to between \$3 million and \$12 million in fiscal year 1995. Costs could be higher or lower depending on the size of the demonstrations.

The bill would authorize the Secretary of HHS to establish a Branch of Health Facilities within IHS to oversee the demonstrations and to provide technical assistance to applicants and grantees. Based on information provided by staff at IHS, CBO estimates that this provision would cost approximately \$250,000 per fiscal year.

6. Estimated cost to State and local Government: None.

7. Estimate comparison: None.

8. Previous CBO estimate: On November 14, 1989, CBO prepared a cost estimate for S. 1270, a bill to provide an Indian mental health demonstration grant program, as ordered reported by the Senate Select Committee on Indian Affairs on November 9, 1989.

9. Estimate prepared by: Karen Graham.

10. Estimate approved by: C.G. Nuckols for James L. Blum, Assistant Director for Budget Analysis.

INFLATIONARY IMPACT STATEMENT

S. 1270, as reported from the Committee, authorizes the appropriation of new funds for Indian health programs. Enactment of this legislation may have a small, but undetermined inflationary impact.

OVERSIGHT STATEMENT

The amendments made to S. 1270 are based upon the results of the Committee's oversight activity on Indian mental health matters in Indian country conducted during the 101st Congress. No recommendations were submitted to the Committee pursuant to rule X, clause 2.

CHANGES IN EXISTING LAW

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill,

as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

ACT OF SEPTEMBER 30, 1976, AS AMENDED

(25 U.S.C. 1601 et seq.)

* * * * *

SEC. 4. For purposes of this Act—

(a) * * *

(m) "*Health Care Delivery Demonstration Project*" means a project approved by the Secretary pursuant to section 307 for Indian tribes to support the design and implementation of innovative approaches for the delivery of cost effective health care to Indians which does not merely replicate existing models of Service and tribal health care programs and which may include, among other things—

(1) innovative use of existing Service health care facilities, resources, and funds;

(2) the infusion of non-Service funds into the construction of Service and tribal health care facilities;

(3) the coordination of Service and non-Service Federal programs, services, and funds; and

(4) cooperative agreements involving Service, tribal, State and local governmental, and private health care facilities and resources for the provision of health care services to Indians and non-Indians in rural communities.

* * * * *

TITLE II—HEALTH SERVICES

IMPROVEMENT OF INDIAN HEALTH STATUS

SEC. 201. * * *

MENTAL HEALTH PREVENTION AND TREATMENT SERVICES

SEC. 208. (a) PURPOSE.—The purpose of this section is to—

(1) authorize and direct the Service to develop a comprehensive mental health prevention and treatment program;

(2) provide direction and guidance relating to mental illness and dysfunctional/self-destructive behavior, including child abuse and family violence, to those Federal, tribal, and State and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and substance abuse, law enforcement, and judicial services;

(3) assist Indian tribes at the local level in identifying existing programs and resources, including those made available by this section;

(4) provide authority and opportunities for Indian tribes to develop, implement, and coordinate community-based mental health programs which include identification, prevention, education, referral, and treatment services, including multidisciplinary resource teams;

(5) ensure that Indian people, as citizens of the United States and of the states wherein they reside, have access to mental health care services to which all citizens are entitled, and

(6) modify or supplement existing programs and authorities in the areas identified in paragraph (2).

(b) **NATIONAL PLAN FOR INDIAN MENTAL HEALTH SERVICES.**—(1) The Secretary acting through the Service, shall develop and publish in the Federal Register a final National Plan for Indian Mental Health Services not later than 120 days after the date of enactment of this section. The plan shall include—

(A) an assessment of the scope of the problem of mental illness and dysfunctional/self-destructive behavior, including child abuse and family violence, among Indian people, including—

(i) the number of Indians served by the Service who are directly or indirectly affected by such illness or behavior, and

(ii) an estimate of the financial and human cost attributable to such illness or behavior;

(B) an assessment of the existing and needed resources necessary to adequately support a program for the prevention and treatment of such illness and behavior among Indian people; and

(C) an estimate of the funding necessary to adequately support such program.

(2) The Secretary shall submit a copy of the National Plan to the Congress.

(c) **MEMORANDUM OF AGREEMENT.**—Not later than 180 days after the date of enactment of this section, the Secretary and the Secretary of the Interior shall develop and enter into a Memorandum of Agreement which shall, among other things,—

(1) determine and define the scope and nature of mental illness and dysfunctional/self-destructive behavior among Indian people;

(2) make a preliminary assessment of the existing Federal, tribal, state and local, and private resources and programs available for inclusion in a coordinated, comprehensive mental health program for Indian tribes;

(3) make an initial determination of the unmet need for resources and programs necessary to identify, prevent, and treat mental illness and dysfunctional/self-destructive behavior, including child abuse and family violence, among Indians;

(4) in carrying out the intent of subsection (a)(5), determine the right of Indians to participate in, and receive the benefit of, mental health services and programs made available to citizens generally and to outline actions necessary to protect the exercise of such right;

(5) delineate the responsibilities of the Bureau of Indian Affairs and the Service to provide mental health identification, prevention, education, referral, and treatment services, including multi-disciplinary resource teams, to Indians at the central area, and agency and service unit levels;

(6) provide a strategy for the coordination of the mental health programs and efforts of such agencies existing on the

date of enactment of this section with other available resources and programs identified pursuant to paragraph (2) and with programs and efforts established by this section;

(7) In the development of the strategy required by paragraph (6), outline plans to ensure that—

(A) the alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and the various tribes be fully coordinated with the mental health initiatives established in this Act, particularly with respect to the referral and treatment of dually-diagnosed persons,

(B) Indian tribes are afforded an equitable opportunity for funding under the Alcohol and Drug Abuse and Mental Health Services Block Grant program (42 U.S.C. 300x et seq.), and

(C) ensure that multi-disciplinary resource teams addressing child abuse and family violence are coordinated with Service and non-Service programs;

(8) direct appropriate officials of the Bureau of Indian Affairs and the Service, particularly at the agency and service unit levels, to cooperate fully with tribal requests made pursuant to subsection (d);

(9) provide for an annual review of such agreement by the two Secretaries; and

(10) provide that funds under subsection (i) shall be available to accomplish the requirements of this section.

(d) **COMMUNITY MENTAL HEALTH PLAN.**—(1) The governing body of any Indian tribe may, at its discretion, adopt a resolution for the establishment of a community Mental Health Plan to identify and coordinate available resources and programs, including resources and programs made available by this section, to identify, prevent or treat mental illness or dysfunctional/self-destructive behavior, including child abuse and family violence, among its members. The resolution adopted by the tribe shall form the basis for the implementation of this section and the Memorandum of Agreement under subsection (c) within the reservation of such tribe.

(2) In furtherance of a Plan to be adopted pursuant to paragraph (1) and at the request of a tribe, the appropriate agency, service unit, or other officials of the Bureau of Indian Affairs and the Service shall cooperate with, and provide technical assistance to, the tribe in the development of such plan. Upon the adoption of a plan by the tribe, such officials, as directed by the Memorandum of Agreement developed pursuant to subsection (c), shall enter into an agreement with the tribe for the implementation of such plan.

(3) Two or more Indian tribes may form a coalition for the adoption of resolutions and the development of a joint Community Health Plan for their members as provided in this subsection.

(4) The Secretary, acting through the Service, may make grants to Indian tribes adopting a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a Community Mental Health Plan and to provide administrative support in the implementation of such plan. There is hereby authorized to be appropriated \$1,000,000 for each of the fiscal years 1992, 1993, and 1994 to carry out this subsection.

(e) **MENTAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.**—(1) *The Secretary and the Secretary of the Interior, in consultation with representatives of Indian tribes, shall conduct a study, and compile a list, of—*

(A) *the types of staff positions within the Bureau of Indian Affairs, including existing positions in the fields of—*

- (i) *elementary and secondary education,*
- (ii) *social services and family and child welfare,*
- (iii) *law enforcement and judicial services, and*
- (iv) *alcohol and substance abuse;*

(B) *types of health care positions within the Service, and*

(C) *staff positions similar to those identified in subparagraphs (A) and (B) established and maintained by Indian tribes, including positions established in contracts entered into pursuant to the Indian Self-Determination Act, the qualifications for which include, or should include, training in the identification, prevention or treatment of mental illness or dysfunctional/self-destructive behavior among Indian people.*

(2)(A) *The respective Secretaries shall provide that training criteria have been, or will be established for each position identified in paragraph (1)(A) and (B), depending upon the functions and responsibilities assigned to such positions, and that the appropriate training has been, or will be, provided to any incumbent of such position.*

(B) *Depending upon the nature of the position, the respective Secretaries shall provide relevant training to, or provide funds to an Indian tribe to support the training of, the incumbents of positions identified in paragraph (1)(C). Where such positions are funded under an Indian Self-Determination Act contract, the appropriate Secretary shall ensure that such training costs are included in the contract, if necessary.*

(C) *If a Plan adopted pursuant to subsection (d) identifies personnel or staff positions, other than those identified pursuant to paragraph (1), which provide services or benefits to Indians on an Indian reservation for which training authorized by this subsection or community education programs are deemed necessary or desirable, such training or community education may be provided from funds authorized pursuant to this subsection.*

(3) *Position-specific training standards in the identification, prevention, and treatment of mental illness and dysfunctional/self-destructive behavior, including child abuse and family violence, among Indians shall be consistent with any national standards for the training of the incumbents of similar positions. However, such training shall also adopt and apply identification, prevention and treatment methods which are culturally relevant to Indian people and Indian communities. Specifically, the respective Secretaries shall ensure that established and recognized traditional Indian healing and treatment practices are considered and, where appropriate, included in any training developed pursuant to this subsection.*

(4) *The Service shall develop and implement or, upon the request of the Indian tribe or tribe served by a service unit, assist such tribes to develop and implement within each service unit a program of community education on mental illness and dysfunctional/self-destructive behavior for persons within the tribal communities as determined in a plan adopted pursuant to subsection (d). In carrying*

out this paragraph, the Service shall provide technical assistance to tribes to obtain or develop community education and training materials on the identification, prevention, referral and treatment of mental illness and dysfunctional/self-destructive behavior.

(5) There is hereby authorized to be appropriated \$5,000,000 for each of the fiscal year 1992, 1993, and 1994 to carry out this subsection, \$1,200,000 of which shall be allocated for community education under paragraph (4).

(f) **STAFFING.**—(1) Within 90 days after the date of enactment of this section, the Secretary shall develop a plan under which the Service will increase the health care staff supported by mental health categorical funds by at least 500 positions within five years after the date of enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. Such additional staff shall be primarily assigned to the service unit level for services which shall include outpatient, emergency, aftercare and follow-up, and prevention and education services.

(2) Implementation of the plan adopted pursuant to paragraph (1) shall be as authorized under the Snyder Act of November 2, 1921 (42 Stat. 208; 25 U.S.C. 13).

(g) **STAFF RECRUITMENT AND RETENTION.**—(1) To support the recruitment of increased personnel authorized by subsection (f) and the retention of all Service personnel devoted to mental health services (particularly services for child and adolescent mental health specialists), the Secretary shall provide that a high priority is given to such needs in implementing the scholarship and manpower provisions of title I of this Act and in any other recruitment and retention efforts of the Department of Health and Human Services.

(2) To assist in the recruitment and retention of mental health professionals as provided in paragraph (1), the Secretary shall develop a plan for the payment of bonuses for service in hardship posts, a loan repayment initiative to recruit such personnel, and a system of postgraduate rotations as a retention initiative.

(3) For the purpose of carrying out special efforts for the recruitment and retention of mental health professionals as provided in this subsection, there is authorized to be appropriated \$1,200,000 for each of the fiscal years 1992, 1993, and 1994.

(h) **MENTAL HEALTH TECHNICIAN PROGRAM.**—(1) Under the authority of the Snyder Act of November 2, 1921 (25 U.S.C. 13), the Secretary shall establish and maintain a Mental Health Technician Program within the Service which—

(A) provides for the training of Indians as mental health technicians, and

(B) employs such technicians in a community-based mental health care program offering identification, prevention, education, referral, and treatment services.

(2) The Secretary shall provide that persons selected for participation in the Mental Health Technician program are provided with high standard paraprofessional training in mental health care necessary to provide quality care to the Indian communities to be served. Such training shall be based upon a curriculum developed or approved by the Secretary which combines education in the theory of mental health care with supervised practical experience in the provision of such care.

(3) The Secretary shall develop and maintain a system which provides close supervision of mental health technicians and which permits the work of such technicians to be reviewed and evaluated.

(4) The Secretary shall ensure that the program established pursuant to this subsection shall involve the utilization and promotion of traditional health care practices of the Indian tribes to be served.

(5) There is hereby authorized to be appropriated \$1,000,000 to provide the training required pursuant to this subsection.

(i) **MENTAL HEALTH RESEARCH.**—(1) The Secretary, acting through the Service and with appropriate collaboration from the National Institute of Mental Health, shall enter into a contract with, or make a grant to, appropriate institutions to conduct research on the incidence and prevalence of mental disorders among Indian populations on Indian reservations and in urban areas as provided in this subsection. Research priorities should include the inter-relationship and interdependence of such mental disorders with alcoholism, suicide, homicides, accidents, and the incidence of family violence and should focus on prevention techniques, with an emphasis on children.

(2) There is hereby authorized to be appropriated to carry out this subsection \$2,000,000.

(j) **FACILITIES ASSESSMENT.**—Within one year after the date of enactment of this section, the Secretary, acting through the Service, shall make an assessment of the need for inpatient mental health care among Indian people and the availability and cost of inpatient mental health facilities which can meet such need. In making such assessment, the Secretary should consider the possible conversion of existing, under-utilized Service hospital beds into psychiatric units to meet such need. There is authorized to be appropriated \$500,000 to make the assessment required by this subsection.

(k) **ANNUAL REPORT.**—The Secretary shall require the Service to develop methods for analyzing and evaluating the over-all status of mental health programs for Indian people and shall submit to the Congress as annual report on the mental health status of Indian people and the progress being made to address mental health problems of Indian communities nationwide.

(l) **MENTAL HEALTH DEMONSTRATION GRANT PROGRAM.**—(1) The Secretary, acting through the Service, is authorized to make at least five grants to Indian tribes or inter-tribal consortia to pay 75 percent of the cost of planning, developing, and implementing programs proposed in applications by such tribes or consortia that will deliver mental health services to Indians through innovative and community-based means. The 25 percent local share of the tribe or tribal consortium may be provided in cash or through the provision of property and services.

(2) In approving applications for grants pursuant to this subsection, the Secretary shall ensure that the grants awarded are not duplicative in the nature and scope of the innovative programs or delivery systems to be demonstrated or the population to be served by the demonstration programs. In addition to other relevant factors, the Secretary, in selecting the applications for approval, shall take into consideration—

(A) the geographical and cultural diversity among the Indian tribes,

(B) the potential impact upon urban Indian mental health problems, and

(C) the variation in mental health problems afflicting different tribes.

(3) Applications submitted pursuant to paragraph (1) shall be in such form as the Secretary may prescribe and shall specify—

(A) the nature of the innovative and community-based means for the delivery of mental health services to be demonstrated in the proposed program;

(B) the data and information upon which the program is based;

(C) the extent to which the program plans to use or incorporate existing service delivery activities;

(D) the specific treatment concepts to be used under the program;

(E) the extent of the planned use under the program of traditional Indian healing and treatment practices; and

(F) a schedule for the completion of the program within three years.

(4) Grants made pursuant to this subsection shall be for a period of three years and no grant shall exceed \$1,000,000 for each of the three fiscal years involved.

(5) The Secretary shall adopt such regulations as are necessary—

(A) for the consideration and approval of applications submitted pursuant to paragraph (1), including the establishment of peer group review panels;

(B) to ensure that the grant funds are expended for the purposes for which the grant was made; and

(C) for the evaluation of the effectiveness of the program in meeting the mental health needs of the population to be served.

(6) Not later than 180 days after the close of the term of the last grant awarded pursuant to this subsection, the Secretary shall submit to the Congress a final report evaluating the effectiveness of the innovative and community-based models tested in the demonstration programs funded and any finding or recommendations relating to the re-organization of the Service's programs for mental health service delivery for Indians.

(7) There is hereby authorized to be appropriated \$3,000,000 for each of the fiscal year 1992, 1993, and 1994 to carry out the purposes of this subsection.

TITLE III—HEALTH FACILITIES

CONSULTATION; CLOSURE OF FACILITIES; REPORTS

SEC. 301. * * *

INDIAN HEALTH CARE DELIVERY DEMONSTRATION PROJECT

SEC. 307. (a) FINDINGS.—The Congress finds that—

(1) there is a unique relationship between the Federal Government and Indian tribes, and this section is not intended to alter that relationship;

(2) every Indian tribe, regardless of its size, should have the ability to provide the highest possible level of health services to its people;

(3) the existing Service facilities construction priority system and resource allocation methodologies shall not be affected by this section;

(4) the existing facilities construction priority system does not serve all tribes and there are some small Indian tribes with a low patient workload at existing facilities which may require reconstitute Service support; and

(5) there exists an Indian health facilities construction backlog which will require at least \$596,000,000 to remedy, and an essential repair backlog which will require at least \$94,000,000 to remedy.

(b) **PURPOSE.**—The purpose of this section is to authorize demonstration projects which are intended to identify the most effective and efficient means of providing access to health care and essential health services for Indians. This section will—

(1) enable Indian tribes to devise alternative health care delivery systems utilizing existing and new Service resources combined with other resources;

(2) enable Indian tribes to develop and implement financing mechanisms for health care services provided through an alternative delivery system; and

(3) enable Indian tribes to fully utilize all available resources for the benefit of community members, whether eligible or ineligible for services provided by the Service, through an existing or alternative health care system.

(c) **HEALTH CARE DELIVERY DEMONSTRATION PROJECTS.**—(1) The Secretary, acting through the Service, is authorized to enter into contracts with, or make grants to, Indian tribes or tribal organizations for the purpose of carrying out a Health Care Delivery Demonstration Project to test innovative health care delivery systems which can, effectively and efficiently, carry out the responsibility of the United States to provide health facilities and services to Indians.

(2) The Secretary, in approving projects pursuant to this section, may authorize funding for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to—

(A) waive any leasing prohibition;

(B) permit carryover of funds appropriated for the provision of health care services;

(C) permit the use of non-Service Federal funds and non-Federal funds;

(D) permit the use of funds or property donated from any source for project purposes; and

(E) provide for the reversion of donated real or personal property to the donor.

(3) In approving applications for demonstration projects pursuant to this section, the Secretary shall—

(A) to the maximum extent feasible, provide for a fair geographic distribution of such projects among the Indian tribes; and

(B) select for consideration and approval projects (including projects approved pursuant to paragraph (4)) which include proposals involving the construction or renovation of facilities—

- (i) with funds from sources other than the Service,
- (ii) with funds from the Service representing not less than 25 percent and not more than 75 percent of the total cost, and
- (iii) with 100 percent funding from the Service, and shall give consideration to the funding of at least one proposal involving each of these funding options.

(4) Notwithstanding paragraph (3) and subject to the availability of funds, the Secretary shall establish, upon the submission of an application meeting the requirements of subsection (d) by the appropriate Indian tribe or tribal organization, a demonstration project located in each of the following Service units:

- (A) Cass Lake, Minnesota,
- (B) Clinton, Oklahoma,
- (C) Harlem, Montana,
- (D) Mescalero, New Mexico,
- (E) Owyhee, Nevada,
- (F) Parker, Arizona,
- (G) Schurz, Nevada,
- (H) Winnebago, Nebraska, and
- (I) Ft. Yuma, California.

(5) No Indian tribe or tribal organization shall be denied eligibility to participate in a project authorized by this section based solely on the financial resources of the tribe or organization.

(d) **PROJECT APPLICATION.**—(1) Any Indian tribe or tribal organization requesting a demonstration project shall submit an application to the Secretary in conformity with the provisions of this subsection (2) The application shall be in such form as the Secretary shall prescribe and shall include—

(A) an assessment of existing health care resources and needs of the community to be served, including—

- (i) a description of the community and area to be served by the project;
- (ii) a complete description and analysis of existing health care facilities and health services currently available to the population served; and
- (iii) a description of funds available of existing health care services and facilities; and

(B) a full description of the proposal for an new or innovative health care delivery system to be operated and tested under such demonstration project, including—

- (i) the need for the project;
- (ii) the data and information on which the proposal is based;
- (iii) a description of the health care services to be provided in connection with the project;
- (iv) a description of any health care facilities to be constructed or renovated under the project, including a schedule for completion of such facilities;

(v) an assessment of the staffing needs for the provision of services and operation of facilities in connection with such project;

(vi) an assessment of the costs of the project and the identification and verification of the funding sources for such project, including a full account of non-Service and non-Federal funds;

(vii) an explanation of the factors which make the demonstration project unique; and

(viii) statements from the tribal governments and organizations, local governments and institutions, and any existing health service delivery systems in the area which would be participating in, or affected by, the demonstration project.

(e) **REVIEW AND APPROVAL OF APPLICATIONS.**—(1) Within 180 days after the date of enactment of this section, the Secretary, after consultation with Indian tribes and tribal organizations, shall develop and publish in the Federal Register criteria for the review and approval of applications submitted for demonstration projects under this section. A copy of the proposed criteria shall be submitted to the Senate Select Committee on Indian Affairs and the House Committee on Interior and Insular Affairs and the House Committee on Energy and Commerce.

(2)(A) The criteria developed pursuant to paragraph (1) shall provide for the establishment by the Secretary of peer review panels, as necessary, to review, evaluate and rank applications submitted pursuant to this section and to make recommendations thereon to the Secretary.

(B) A panel established pursuant to this paragraph shall include at least one member who is a tribal representative, a Service employee, an expert in rural health, and an expert in health facility construction and program implementation.

(C) In reviewing, evaluating and ranking applications pursuant to this paragraph, review panels shall consider, among other things,—

(i) whether the demonstration project will provide innovative health services to Indian people;

(ii) the benefit or benefits to the Indian community in the operation of the demonstration project;

(iii) the extent to which health services for Indians will be enhanced as a result of the demonstration project;

(iv) whether the project will provide new or expanded services within the existing health care delivery system, including, but not limited to, service such as home-based care or swing-bed services;

(v) the combined Indian/non-Indian patient workload in the project service area, specifically with reference to average daily patient workloads and the impact of the project on improved quality of care;

(vi) the economic viability of the proposed health care delivery or financing system and tribal administrative capability to provide the proposed services;

(vii) a determination of the cost-benefit ratio of the project, taking into account the patient population workload and improvement in the quality of care;

(viii) improved Indian patient access to health care resources and the value of such access in relation to Federal funding and the overall health benefits to the Indian tribe;

(ix) identification of barriers to use of state resources;

(x) how the project will integrate with area facility master plans, other national and area strategies for eliminating health deficiencies in accordance with this Act and how the project brings about an improvement in the level of need funded under this Act;

(xi) whether health care services for the Indian community be served will be impaired or diminished by the proposed project; and

(xii) the ability of the Department of Health and Human Services to support functions of the Department that are related to the demonstration project.

(f) **TECHNICAL ASSISTANCE.**—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this Act.

(g) **BRANCH OF HEALTH CARE DELIVERY DEMONSTRATION PROGRAMS.**—The Secretary shall establish, within the Indian Health Service, a Branch of Health Care Delivery Demonstration Programs within the Office of Health Programs to oversee the demonstration projects established under this Act and to coordinate the provision of technical assistance to applicants and grantees.

(h) **SERVICE TO INELIGIBLE PERSONS.**—The authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-Service health care practitioners as provided in section 713 of this Act may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section.

(i) **REPORT TO CONGRESS.**—(1) Within 90 days after the end of the period set out in subsection (c), the Secretary shall, in consultation with tribes involved in approved demonstration projects, prepare and submit to Congress a report, together with legislative recommendations, on the findings and conclusions derived from the demonstration projects.

(2) In addition, the report shall notify the Congress of the Secretary's intention to make permanent, discontinue, or substantially modify each of the demonstration projects. Congress shall have one year to respond before the Secretary takes action to modify or discontinue any of such projects.

(j) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out the provisions of this section, there are authorized to be appropriated such sums as may be necessary.

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TITLE V—HEALTH SERVICES FOR URBAN INDIANS PURPOSE

SEC. 501. * * *

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CONTRACTS FOR THE PROVISION OF HEALTH CARE OR REFERRAL
SERVICES

SEC. 503. (a) * * *

I(c)(1) The Secretary, acting through the Service, shall facilitate access to, or provide, health promotion and disease prevention services as defined in section 4 (k) and (l) of this Act for urban Indians through grants made to organizations administering contracts entered into pursuant to this section.

(2) There is authorized to be appropriated \$1,000,000 for each of the fiscal years 1992, 1993, and 1994 to carry out this subsection.

(d)(1) The Secretary, acting through the Service, shall facilitate access to, or provide, immunization and immunization services for urban Indians through grants made to organizations administering contracts entered into pursuant to this section. Funds may be made available pursuant to this subsection—

(A) for printing and disseminating educational or other materials related to immunization services;

(B) for the purchase of vaccines and other supplies needed to provide immunization services to patient populations, particularly infants, children, and the elderly; and

(C) to provide personnel to deliver immunization services.

(2) In making grants to carry out this subsection, the Secretary shall take into consideration—

(A) the size of the urban Indian population to be served;

(B) immunization levels of patient population, particularly infants, children, and the elderly;

(C) the availability of alternative resources from State and local governments for no-cost or low-cost immunization services to the general population and factors related to the utilization patterns of these services by urban Indians; and

(D) the capability of the urban Indian organization to carry out services pursuant to this subsection.

(3) There is authorized to be appropriated \$1,000,000 for each of the fiscal years 1992, 1993, and 1994 to carry out this subsection.

(e)(1) The Secretary, acting through the Service, shall facilitate access to, or provide, mental health services for urban Indians through grants made to organizations administering contracts entered into pursuant to this section.

(2) The Secretary may make such grants—

(A) to conduct a mental health needs assessment of urban Indian communities to assess the mental health needs of the community, available resources, barriers to accessing those resources, and gaps in services; and

(B) to develop a plan to improve those services.

(3) Where an urban Indian organization has conducted a needs assessment as provided in paragraph (2) or where the Secretary has determined such organization has already developed such an assessment, the Secretary may make a grant to such organization—

(A) to provide outreach, educational, and referral services to urban Indians to provide a linkage to available direct mental health services, educate the urban Indian community about mental health issues and services, and network with existing mental health providers to improve services to Indians;

(B) to provide outpatient mental health services, including identification and assessment of illness, therapeutic treatment, case management, support groups, family treatment, and other treatment; and

(C) to develop innovative mental health service delivery models which incorporate Indian cultural support systems and resources.

(3) There is authorized to be appropriated \$2,000,000 for fiscal year 1992, \$3,500,000 for fiscal year 1993, and \$5,000,000 for fiscal year 1994 to carry out this subsection.

(f)(1) The Secretary, acting through the Service, shall facilitate access to, or provide, services for urban Indians through grants to organizations administering contracts entered into pursuant to this section to prevent and treat child abuse (including sexual abuse) in urban Indian communities. Funds may be made available pursuant to this subsection—

(A) to conduct a needs assessment as required by paragraph (2)(C) of this subsection;

(B) for the development of prevention, training and education programs for urban Indian communities, including child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and establishing service networks of all those involved in Indian child protection; and

(C) to provide direct outpatient treatment services in Indian urban communities (including individual treatment, family treatment, group therapy, and support groups) to child victims of abuse (including sexual abuse), adult survivors of child sexual abuse, families of child victims, and perpetrators of child abuse (including sexual abuse).

(2) In making grants to carry out this subsection, the Secretary shall take into consideration—

(A) the support for the urban Indian organization demonstrated by the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act (25 U.S.C. 1901 et seq.), if any;

(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

(C) a needs assessment, submitted by the urban Indian organization before requesting funding under this subsection, which documents the prevalence of child abuse in the Indian community and the proposed services which do not duplicate existing services and which are approved by the Service.

(3) There is authorized to be appropriated \$2,000,000 for fiscal year 1992, \$3,500,000 for fiscal year 1993, and \$5,000,000 for fiscal year 1994 to carry out this subsection.

(g)(1) The Secretary shall conduct a survey of all facilities used by a contractor under this title and shall submit a report to the Congress on such survey one year after the date of enactment of this subsection. The report shall, at a minimum, contain the following information for each location—

(A) the extent to which the facility meets life safety and building codes and, if direct care is provided, the extent of com-

pliance with Joint Commission for Accreditation of Health Care Organizations (JCAHO) standards;

(B) the extent to which improvements, expansion, or relocation is necessary to meet program requirements, provide adequate services, or achieve building code compliance;

(C) any lease restrictions that would hamper accomplishment of needed improvement, expansion, or relocation;

(D) the term of the lease, if appropriate, the age of the structure, and the structure's life expectancy with and without improvement; and

(E) site specific overall assessments.

(2) The report shall contain general recommendations for addressing the deficiencies of facilities in which programs funded under this title are located and shall propose specific program policies for accomplishing those recommendations.

(3) The Secretary may make funds available to contractors under this title for minor renovations to facilities, including leased facilities, to assist such contractors in meeting or maintaining JCAHO standards and there is hereby authorized to be appropriated \$1,000,000 for fiscal year 1992, \$1,500,000 for fiscal year 1993, and \$2,000,000 for fiscal year 1994 for that purpose.

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SEC. 507. (a) * * *

(d)(1) The Secretary, acting through the Service, shall submit a report to the Congress in March of 1992, 1993, and 1994 evaluating—

(A) the health status of Indians in urban areas;

(B) the services provided to Indians through this title; and

(C) areas of unmet need, including urban areas not served pursuant to this Act.

(2) In preparing the report under paragraph (1), the Secretary shall consult with urban Indian health providers and may contract with a national organization representing urban Indian health concerns to conduct any aspect of the report.

(3) The Secretary and the Secretary of the Interior shall report to Congress no later than March 1992 their assessment of the status of Indian child welfare in urban communities, including information as to the volume of child protection cases, the prevalence of child sexual abuse, the extent of urban coordination with tribal authorities, and their legislative recommendations to improve Indian child protection in urban communities.

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URBAN HEALTH PROGRAMS BRANCH

SEC. 509. (a) There is hereby established within the Office of Health Programs of the Indian Health Service, as a part of the Division of Clinical and Preventive Services, a Branch of Urban Health Programs which shall be responsible for carrying out the provisions of this title.

(b) The Secretary shall appoint such employees to work in the Branch, including a Program Director, and shall provide such services and equipment as may be necessary for it to carry out its respon-

sibilities. The Secretary shall also analyze the need to provide at least one urban health program analyst for each area office of the Indian Health Service and shall submit his findings to the Congress as a part of the Department's fiscal year 1993 budget request.

INDIAN ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND
TREATMENT ACT

(25 U.S.C. 2401 et seq.)

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SEC. 4227. INDIAN HEALTH SERVICE YOUTH PROGRAM.

(a) DETOXIFICATION AND REHABILITATION.— * * *

* * * * *

(b) TREATMENT CENTERS OR FACILITIES.—(1) * * *

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(3) Notwithstanding any other provision of this subtitle, the Secretary may, from amounts authorized to be appropriated pursuant to this section, make funds available to the Tanana Chiefs Conference, Incorporated, for the purpose of leasing, operating, and maintaining a residential youth treatment facility in Fairbanks, Alaska.



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